|  |  |  |  |
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| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500  P.O. BOX 1715  Columbia, SC 29202-1715  (803) 737-5675 [www.wcc.sc.gov](http://www.wcc.sc.gov) | SCSealBWjpg | | **PRE-HEARING BRIEF**  **WCC File No:\_\_\_\_\_\_\_\_\_\_\_\_** |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | | | |  | |  | | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Home Phone: | (     )    - | | Work Phone: | (     )    - | | | |  |  | |  | |  | | | Preparer's Name: | |  | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  | | --- | --- | | Carrier: |  |      |  |  | | --- | --- | | Preparer’s Phone #: | (     )    - | |  |  | | |

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| **A claim for workers’ compensation benefits is made based on the following grounds:**  Injury  Illness  Repetitive Trauma | | | | | | | | | | | | |
|  | Compensation Rate: | | |  | | | | 1. AWW: | $ | | **Date of Injury:** |  |
|  | Type of injury and body part(s): | | | | | |  | | | | | |
|  | Facts in controversy: | | | |  | | | | | | | |
|  |  | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Legal issues involved: | | | |  | | | | | | | |
|  |  | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Unusual aspects: | |  | | | | | | | | | |
|  | Witnesses (designate if expert):\* | | | | |  | | | | | | |
|  |  | | | | | | | | | | | |
|  | Exhibits: |  | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Name, address, and specialty, if any, of the treating physician: | | | | | | | | |  | | |
|  |  | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Impairment rating(s); body part(s); physician and date of opinion: | | | | | | | | | | | |
| 12. | I am amending my Form 50/51 in the following manner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |

**Mediation**

a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.

b. Mediation is required pursuant to Reg. 67-1802.

c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to [**mediation@wcc.sc.gov**](mailto:mediation@wcc.sc.gov)**.**

**I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to**

**Address on the       day of** **20****, by:**

**first class postage**  **certified mail**  **personal service  electronic service**

**I verify the contents of this form are accurate and true to the best of my knowledge.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  | | Email: |  |  |
| Date of hearing: | |  | Time needed for hearing: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67- 1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. \* Commissioners reserve the right to admit expert witnesses at hearings.   |  |  |  | | --- | --- | --- | | **WCC Form # 58**  Revised 7/15 | 58 | PRE-HEARING BRIEF | |